Brentwood Behavorial Healthcare of MS
3531 Lakeland Drive Flowood, MS 39232
Phone 601-936-2024 or 1-800-863-4004 / Fax 601-936-7848 / 601-420-6250
A Subsidiary of Psychiatric Solutions, Inc.

Authorization to Use or Disclose Protected Health Information

(Patient/Resident Name) (Date of Birth) (SS#) (Date(s) of Treatment)

I hereby freely and voluntarily authorize Brentwood Behavioral Healthcare of MS to . . .

______ Release/disclose my protected health information to:

______ Obtain my protected health information from:

(Individual, Facility, or Organization) (Phone Number)

(Address) (Fax Number)

(City, State, Zip Code)

The purpose of this disclosure is for:

__ insurance purposes __ educational placement __ legal reasons __ medical treatment
__ discharge planning __ continued treatment __ the patient __ progress updates
__ other (explain) __________

Information to be used or disclosed:

__ Discharge summary __ Psychiatric Evaluation __ Mental Status __ History & Physical
__ Psychological testing __ Treatment Plan(s) __ Lab/X-ray results __ Progress Report
__ Psychosocial assesment __ Immunization status __ Physician's Orders __ Substance Abuse Tx
__ Aftercare Plan/Cont. Care __ Verbal communication __ Clinical Assessment __ Dates of Service Letter
Other (explain) __________

I understand that my medical records may contain information regarding testing, drug, and/or alcohol diagnosis and treatment, a communicable or veneral disease which may include, but is no limited to, diseases such as hepatitis, syphilis, gonorrhea, or the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS) and/or tuberculosis. I understand that such information is confidential and is protected by federal law. I understand that the provision of helath care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health infohmation for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to the Brentwood Privacy Officer, except tot he extent that action has already been taken in reliance on it. This authorization will expire 180 days (x) following discharge, or ( ) following signature unless another date or condition is specified. Other date or condition specified: __________.

Signatures:

(Patient/Resident - When applicable by law or hospital policy) *(Date)*

(Guardian or Representative) *(Date)* *(Relationship to Patient/Resident)*

(Witness) *(Date)*

*Drug and alcohol records are protected by Federal sonfidentiality ruling (42 CFR part 2) and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

OFFICE USE ONLY: Date: __________ Mailed Faxed

AUDPHI